TRAUMATIC INJURY PROTECTION (TSGLI)
UNDER THE
SERVICE MEMBERS' GROUP LIFE INSURANCE PROGRAM
CERTIFICATION FORM AND INSTRUCTIONS

Administered by the
Office of Servicemembers' Group Life Insurance
290 West Mount Pleasant Avenue
Livingston, NJ 07039-2747
Toll Free Telephone: 1-800-419-1473
Toll Free FAX: (877) 832-4943

TSGLI Certification Package, Edition September, 2005

OMB Control Number: 2900-06-71
Respondent Burden: 30 minutes

HOW TO CERTIFY PAYMENT OF TRAUMATIC INJURY PROTECTION (TSGLI)

TSGLI

Effective December 1, 2005, service members who are insured under SGLI and suffer a loss from a traumatic injury are eligible to receive monetary compensation for a total amount not less than $25,000 and not greater than $100,000.

Form GL.2005.261

To submit a certification, the service member, the attending medical professional, and the branch of service must each complete this form in accordance with the instructions on the next page.

Method of Payment

Electronic Funds Transfer (EFT)

The benefit will be electronically credited to the bank account specified. This account should be the account of record for payroll purposes. If EFT is not chosen, and there is no guardian or Attorney in Fact, the payment will be made through Prudential's Alliance Account.

Prudential's Alliance Account®*

The benefit will be deposited into Prudential's Alliance Account in the service member's name. The Alliance Account offers the following features:

A personal interest bearing account, which gives the service member ready access to the money, whenever it is needed. To use the account, the service member can simply write a check for the withdrawal amount. The minimum withdrawal is $250. The service member may write out one check for the entire amount and close the account, or write checks as the money is needed. Interest will continue to be earned on any balance maintained in the account.

What Else You Should Know

TSGLI will be paid directly to the member, **EXCEPT when:**

The member is incompetent –

- In such event, payment will be made by check or EFT to the member's Guardian or Attorney in Fact under a Durable Power of Attorney. Please include copies of letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. In this case, Alliance Account payment is not an option.

The member dies after qualifying for payment but before payment can be made –

- In such event, payment will be made to the member's listed SGLI Beneficiary(ies).

What should be done with the completed certification form?

Once the form is completed, please send it to OSGLI, by toll free fax to 1-877-832-4943, or by mail to:
OSGLI-TSGLI Claim Processing, 290 West Mt. Pleasant Avenue, Livingston, NJ 07039-2747

Any questions regarding the completion of this form, please call OSGLI toll free at 1-800-419-1473 Or e-mail us at osgli.claims@prudential.com.

* Prudential's Alliance Account is a registered trademark of The Prudential Insurance Company of America. BISYS Information Solutions, L.P. is the Administrator of the Prudential Alliance Account Settlement Option, a contractual obligation of The Prudential Insurance Company of America, located at 751 Broad Street, Newark, NJ 07102-3777. Check clearing is provided by Bank One and processing support is provided by Integrated Payment Systems, Inc. Alliance Account balances are not insured by the Federal Deposit Insurance Corporation (FDIC). BISYS Information Solutions, L.P., Bank One, and Integrated Payment Systems, Inc. are not Prudential Financial companies.

INSTRUCTIONS

PART A – To be completed by Service Member

Section 1 – Service Member Information

Section 1 of the form requests identifying information for the service member on whose behalf the benefit will be paid.

Section 2 – Guardian or Attorney in Fact Information

If anyone other than the service member will receive payment, please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the benefit. If there is a Guardian or Attorney in Fact, Alliance Account payment is not an option.

Section 3 – Payment Information

Section 3 requests selection of a payment method for the TSGLI benefit. Only one method of payment should be selected. If payment is being made to the service member, only EFT or Alliance Account may be selected. If payment is being made to a guardian or Attorney in Fact, only EFT or check may be selected.

If the payment is to be deposited electronically into the service member's account, please check the Electronic Funds Transfer (EFT) box and complete the banking information. All information is required.

If the payment is to be deposited into an Alliance Account and a checkbook mailed to the service member, please check the Prudential's Alliance Account® box and complete the address to which the checkbook should be sent. Alliance Account checkbooks are sent by overnight delivery and, therefore require a street address. They cannot be delivered to Post Office boxes.

If neither method is indicated on the form, and there is no guardian or Attorney in Fact, the benefit will be paid through the Alliance Account. The checkbook will be mailed to the address of record listed in Section 1.

Section 4 – Signature

The service member, guardian, or Attorney in Fact must sign this section.

Section 5 – Authorization to Release Information

The Authorization to Release Information must be completed and signed by the service member, guardian, or Attorney in Fact.

PART B – Medical Professional's Statement

The Medical Professional's Statement asks the attending medical professional (military or civilian) to give details of the injuries that qualify the service member for the TSGLI benefit. The service member should complete Item 1, Service Member's Name and fill in the his or her Social Security Number at the top of both pages.

The attending medical professional must complete all sections that are applicable to the service member's injuries. Where a narrative description is required, please be complete and concise. For all sections, except the signature, please type or print legibly.

PART C – To be completed by the Branch of Service (after receipt of completed parts A and B by the Branch of Service)

Section 6 – Traumatic Event Information

Section 6 of the form requests information about the traumatic event that caused the service member's injuries.

If the service member is deceased, please submit a copy of the Report of Casualty (DD-1300) and Form SGLV-8286, indicating the SGLI beneficiaries.

Section 7 – Certification by Branch of Service

Section 7 of the form requests the Branch of Service to certify the service member's SGLI coverage and to verify that the event that caused the service member's injuries qualifies under the regulations that govern this coverage. If the service member had declined SGLI coverage, please submit a copy of the Form SGLV-8286 indicating the declination.

Certification of Traumatic Injury Protection (TSGLI)
Part A—To Be Completed by Service Member

1 Service member Information

First Name | MI | Last Name

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Male ☐ Female

Branch of Service | ☐ Active Duty ☐ Reserves ☐ National Guard | Telephone

Address of Record (number and street) | Apartment (if any)

City | State | ZIP Code

E-mail Address

2 Guardian or Attorney in Fact Information

Important Note: Please include copies of the letters of guardianship, conservatorship, or Power of Attorney, etc. with this form. Failure to include this documentation will delay payment of the claim.

If a guardian or an Attorney in Fact will receive payment, please complete the following:

First Name | MI | Last Name

Mailing Address (number and street) | Apartment (if any)

City | State | ZIP Code

Telephone Number | Fax Number

3 Payment Information (Please select only one method of payment)

☐ **Electronic Funds Transfer (EFT)** (Available to service member, guardian, or Attorney in Fact)

Bank Name | Bank Phone Number

Bank Routing Number | Bank Account Number | ☐ Savings ☐ Checking

Account Owner's Name

First Name | MI | Last Name

Note: Please enter street address only. No P.O. Boxes

☐ **Prudential's Alliance Account®*** (Available to service member only)

Mailing Address for Payment | Apartment, Ward or Room (if any)

City | State | ZIP Code

☐ **Payment by Check** (Available to guardian, or Attorney in Fact)

4 Signature

X

Signature of service member, guardian, or Attorney in Fact | Date (MM DD YYYY) | Description of Authority

Service member's Social Security Number

Certification of Traumatic Injury Protection (TSGLI)

5 Authorization for Release of Information to Branch of Service and Office of Servicemembers' Group Life Insurance

This authorization is intended to comply with the HIPAA Privacy Rule

Name of Insured:

First Name | MI | Last Name

Date of Birth (MM DD YYYY) | Social Security Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, medical examiner or other health care provider that has provided treatment, payment or services pertaining to:

First Name | MI | Last Name

Print Name of Service member

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to the Branch of Service and Office of Service members' Group Life Insurance (OSGLI) and its agents, employees, and representatives. Office of Servicemembers' Group Life Insurance (OSGLI) is a division of The Prudential Insurance Company of America, headquartered in Newark, New Jersey. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to OSGLI.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that my Branch of Service and OSGLI may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits, 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with OSGLI.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to OSGLI at: 290 West Mount Pleasant Avenue, Livingston, NJ 07039. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that OSGLI has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, OSGLI may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

*Limits, if any:

X

Signature of service member, guardian or Attorney in Fact | Description of Authority

Date (MM DD YYYY)

Certification of Traumatic Injury Protection (TSGLI)
Part B—To Be Completed by Attending Medical Professional

Service member's Social Security Number

1. Patient's Name

First Name | MI | Last Name

2. Date of Injury (MM DD YYYY)

3. What was the injury/diagnosis resulting in this claim? (Please print or type)

If patient is deceased, please provide:

1. Date of Death (MM DD YYYY)

2. Time of Death ☐ A.M. ☐ P. M.

3. Cause of Death

Amputation

If claim is for loss of limbs or digits, please indicate:

Right hand at or above wrist — Date of Amputation (MM DD YYYY)

Left hand at or above wrist — Date of Amputation (MM DD YYYY)

Right foot at or above ankle — Date of Amputation (MM DD YYYY)

Left foot at or above ankle — Date of Amputation (MM DD YYYY)

Right Thumb — Date of Amputation (MM DD YYYY)

Left Thumb — Date of Amputation (MM DD YYYY)

Thumb and index finger of the right hand — Date of Amputation (MM DD YYYY)

Thumb and index finger of the left hand — Date of Amputation (MM DD YYYY)

Loss of Sight, Speech, or Hearing

If claim is for total permanent loss of sight, please give date when this occurred:

Right Eye (MM DD YYYY)

Left Eye (MM DD YYYY)

If claim is for total permanent loss of speech, please give date when this occurred:

Date of onset (MM DD YYYY)

If claim is for total permanent loss of hearing, please give date when this occurred:

Right Ear (MM DD YYYY)

Left Ear (MM DD YYYY)

Paralysis

If claim is for paralysis please complete the following:

Type of Paralysis:

☐ Hemiplegia ☐ Quadriplegia ☐ Paraplegia

Date of Onset of Paralysis (MM DD YYYY)

Brain Injury or Coma

If claim is for coma please complete the following:

Date of Onset of Coma (MM DD YYYY)

Duration of Coma:

☐ 15 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

If claim is for the inability to carry out activities of daily living as a result of traumatic brain injury, please complete the following:

Date of Onset (MM DD YYYY)

Which of the following functions cannot be independently performed?

☐ Dressing ☐ Bathing ☐ Toileting ☐ Eating ☐ Continence ☐ Transferring

Duration

☐ 15 Days ☐ 30 Days ☐ 60 Days ☐ 90 Days

Certification of Traumatic Injury Protection (TSGLI)
Part B—To Be Completed by Attending Medical Professional

Service member's Social Security Number

Burns

If claim is for burns, please complete the following:

Are there third degree burns to:

a. Face? ☐ No ☐ Yes - Please indicate percentage of face affected by third degree burns ☐☐☐ %

b. Body? ☐ No ☐ Yes - Please indicate percentage of body affected by third degree burns ☐☐☐ %

Other Traumatic Injuries

If claim is for the inability to carry out activities of daily living as a result of traumatic injury other than brain injury, please complete the following:

Date of Onset (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

Which of the following functions cannot be independently performed?

☐ Dressing ☐ Bathing ☐ Toileting ☐ Eating ☐ Continence ☐ Transferring

Duration

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days

Comments (if any):

Medical Professional's Signature

Name of Attending Medical Professional (Please Print)

First Name | MI | Last Name

Medical Professional's Address (number and street) | Suite

City | State | ZIP Code

Telephone Number | Fax Number

If civilian medical professional, please complete:

Specialty

License Number | State of License

If military medical professional, please complete:

Rank | Branch of Service

Date (MM DD YYYY) ☐☐ ☐☐ ☐☐☐☐

X _____
Signature

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

Certification of Traumatic Injury Protection (TSGLI)
Part C—To Be Completed by Branch of Service

Service member's Social Security Number

6 Traumatic Event Information

Date of Traumatic Event (MM DD YYYY)

Was the service member on duty when the event occurred? ☐ Yes ☐ No

Time of Event-Please use Zulu time (HH MM) :

Hostile Action? ☐ Yes ☐ No

Geographic location where injury occurred

Description of Traumatic Event

If service member is deceased, please attach Report of Casualty (DD 1300) and Form SGLV – 8286, indicating SGLI beneficiaries.

Date of Death (MM DD YYYY)

Cause of Death

7 Certification by Branch of Service

Was service member covered under SGLI at the time of the traumatic event?

☐ Yes ☐ No-Please attach a copy of the form 8286 declining coverage

Does the traumatic injury event qualify for Traumatic Injury Protection (TSGLI) under 38CFR9.20? ☐ Yes ☐ No

If No, please explain

Are you aware of a guardian or Attorney in Fact being appointed for the service member? ☐ Yes ☐ No

8 Signature

Name and rank of person certifying sections 6 and 7 above. (Please Print)

First Name MI Last Name

Rank or Civilian Title

Telephone Number

Fax Number

Certifying/Contact Office Name

Address Line 1

Address Line 2

City State ZIP Code

Use reverse side of this form for additional comments. Please print or type clearly.

Date (MM DD YYYY)

X

Signature of person certifying sections 6 and 7 above

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

CERTIFICATION OF TRAUMATIC INJURY PROTECTION (TSGLI)

Additional comments (if any):